PA07-2002: PROTON PUMP INHIBITOR REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX OR MAIL TO:
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO BOX 25719
RICHMOND VA 23286-8212
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ MEDICAID ID CARD NUMBER: _____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
_____
OFFICE PHONE NUMBER ( ) _____- _____
REQUESTER NAME: _____ RN /MD /R.PH / ____
PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____
DRUG REQUESTED _____ STRENGTH _____
REQUEST TYPE (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE _____ UNITS / RX _____
DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) DOSING FREQUENCY: _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

HYPERSECRETORY CONDITIONS
ICD9 CODE:

GASTROESOPHAGEAL REFLUX DISEASE
ICD9 CODE:

HISTORY OF GI COMPLICATION
ICD9 CODE:

Patient has had an occurrence of either: GI Bleed Hemorrhage Perforation (Circle One)

UNCOMPLICATED PEPTIC ULCER DISEASE (PUD)
ICD9 CODE:

Has patient received a prescription for a NSNSAID in the past 180 days?	*Yes*	/	*No*
Is the patient 75 years of age or older?	*YES*	/	*NO*
Has the patient been tested for H. Pylori within the last 3 months?	*YES*	/	*NO*
Has the patient been treated for H. Pylori within the last 3 months	*YES*	/	*NO*

CYSTIC FIBROSIS
ICD9 CODE:

NSAID THERAPY WITH GI TOXICITY RISK FACTORS
ICD9 CODE

MUST HAVE PRESENCE OF AT LEAST ONE GI TOXICITY RISK FACTOR OR DOCUMENTED THERAPEUTIC FAILURE OF ONE NONSELECTIVE NSAID OR APAP

Has patient received a prescription for a nsnsaid in the past 180 days?	*Yes*	/	*no*
Is the patient 75 years of age or older?	*YES*	/	*NO*
Does the patient have a history of PUD or GI Bleed?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and corticosteroids?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and oral anticoagulants?	*YES*	/	*NO*

RHEUMATOID ARTHRITIS
ICD9 CODE:

GASTRITIS
ICD9 CODE:

MUST HAVE 2 diagnosis in past 6 months plus prior trial prescription or OTC H2 receptor antagonist

*Diagnosis 1*_____ *Date:* _____ *Diagnosis 2* _____ *Date:* _____

AND *Trial of H2 receptor antagonist Yes No (Circle One)* *Name of trial medicine* _____

POSTERIOR LARYNGITIS (OMEPRAZOLE ONLY)
ICD9 CODE:

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____
APPROVED_____ **DENIED** _____
PENDING ADDITIONAL INFORMATION_____
DATE /TIME OF RECEIPT _____
DATE/TIME RESPONSE _____
REVIEWER _____
COMMENTS:

RI PRIOR AUTHORIZATION CALL CENTER
FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)
PHONE NUMBER 1-866-420-3874

RI Prior Authorization - Call Center Hours
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
SATURDAYS 9:00 AM – 1:00 PM (EST)